



Virginia Board of Dentistry Practitioner Questionnaire

Please **PRINT** or type any information that is not provided. Please note that if you choose to include optional information, it will be part of your profile. For questions please see the Reference at the end of this form.

1. **Name:** **License Number:**

Maiden Name (optional)

If you have a name change, notify the Board in writing and include legal documentation that supports the change.

2. **Address of Record** (used to receive license renewals, notifications, and orders. This address is not included in your profile.)

City: **State:** **Zip:**

E-mail (optional): **Website (optional):**

3. **Do you have a Primary Practice Address?** Yes: ☐ No: ☐

Practice Name (optional): **Address:**

City: **State:** **Zip:**

Percentage of time practitioner spends at this location: %

Optional Days of the week patients are seen at this location (i.e. M-W,F):

Optional Telephone : [Example (804) 555-1212]

Translating service available: Yes: ☐ No: ☐

Foreign language spoken in office. Please select from Code List A

(attach additional sheets if necessary):

Foreign language spoken by practitioner. Please select from Code List A

(attach additional sheets if necessary):

4. **Do you have an Additional Practice Address?** Yes: ☐ No: ☐

Practice Name: (optional) **Address:**

(attach additional sheets if necessary)

City: **State:** **Zip:**

Percentage of time practitioner spends at this location: %

Optional Days of the week patients are seen at this location (i.e. M-W,F):

Optional Telephone:

Optional Translating service available: Yes ☐ No: ☐

Optional Foreign language spoken in office. Please select from Code List A

(attach additional sheets if necessary):

Optional Foreign language spoken by practitioner. Please select from Code List A

(attach additional sheets if necessary):

5. **Education.** Year of Completion: School Code

Please select the code from Code Lists B1: medical or B2: dental school attended (attach additional sheets if necessary):

If you attended a non-US (and territories) or non-Canadian school, please enter the name of the school below:

School Attended:

State or Province: Country:

6. **Post Graduate Education.** Please indicate the name of the post graduate medical or dental education program attended as approved by the Accreditation Council for Graduate Medical Education or the Commission on Dental Accreditation, American Dental Association (attach additional sheets if necessary):

Choose one

Specialty: Internship: ☐

Program Name: City: Residency: ☐

State or Province: Country: Year of Completion: Fellowship: ☐

Specialty: Internship: ☐

Program Name: City: Residency: ☐

State or Province: Country: Year of Completion: Fellowship: ☐

Specialty: Internship: ☐

Program Name: City: Residency: ☐

State or Province: Country: Year of Completion: Fellowship: ☐

7. **Board Eligibility.** Are you currently Board eligible or qualified but not fully Board certified as approved by the American Dental Association's Council on Dental Education and

Yes: ☐ No: ☐

If yes, please indicate the code(s) from Code List for your Board eligibility (attach additional sheets if necessary):

Code: Code: Code:

8. **Board Certification.** Are you currently Board certified as approved by the American Dental Association's Council on Dental Education and Licensure?

Yes: ☐ No: ☐

If yes, please indicate the initial year of certification/sub-certification, the year of expiration, and the code(s) from Code List (attach additional sheets if necessary):

Code: Year of Certification: Year of Expiration:

Code: Year of Certification: Year of Expiration:

9. **Cosmetic Procedures Area.** Please indicate the code from List D cosmetic procedures you are certified to perform (attach additional sheets if necessary):

Code: Code: Code:

10. Active/clinical practice. Please indicate total number of years in active/clinical practice following completion of graduate medical or dental education:

Number of years in active/clinical practice inside US/Canada/US Territories:

Number of years in active/clinical practice outside US/Canada/US Territories:

11. Medicaid.

Do you participate in the Virginia Medicaid Program?

Yes **No**

☐ ☐

Are you accepting new Virginia Medicaid patients?

☐ ☐

12. Medicare. Optional

Yes **No**

Are you a Medicare participating provider?

☐ ☐

Are you a Medicare non-participating provider?

☐ ☐

Are you accepting new Medicare patients?

☐ ☐

13. Virginia Hospitals. Please indicate from Code List E all the Virginia hospitals/facilities at which you have affiliations. Please indicate the type of privilege next to each Hospital Code. (attach additional sheets if necessary):

Hospital Code	Type of Privilege
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

14. Out of state hospital privileges and affiliation. Please list the hospital name, type of privilege, city and state for all hospital privilege/affiliations in all states other than Virginia. (attach additional sheets if necessary):

Hospital	Privilege Type	City and 2 digit StateAbbreviation
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

15. US Academic Appointments. Please indicate US/Canada/US Territories academic appointments to dental school facilities in the most recent 10 year period. Use Code List B2 to select the codes for the school(s) and Code List F for the rank (attach additional sheets if necessary):

School Code:	Rank Code:	Years of Service: (such as 1997-1999)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

- 16. Non-US Academic Appointments.** Please list non-US/Canada/US Territories academic appointments to dental school facilities in the most recent 10 year period. Provide the full name and country for the school and use Code List F for the rank (attach additional sheets if necessary):

School:	Country:	Rank Code:	Years of Service: (such as 1997-1999)

- 17. Publications.** Please list publications in peer-reviewed literature within the last five years (maximum of ten articles). Please include Title, Journal, Volume, Date, and Website Address (attach additional sheets if necessary):

- 18. Continuing Education** If you wish to provide information on hours of
Optional Continuing Education earned, please complete the following: ____ hours of
 Continuing Education earned since the year _____.

- 19. Honors and Awards.** If you wish to provide information on honors or awards
Optional received, please indicate the date the honor or award was received, the name of the
 organization bestowing the honor or award, and what the honor or award consisted of.
 You may also use this section to include board certifications that are not recognized by
 the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of the
 American Osteopathic Association, or the Council on Podiatric Medical Education of the
 American Podiatric Medical Association.

- 20. Actions 1.** Have you ever had any disciplinary action taken by a professional licensing board in a state other than Virginia, or by a federal health institution, federal agency, or the voluntary surrender of a license in a state other than Virginia while under investigation?

Yes: ☐ No: ☐ *If yes, please complete the sections below (attach additional sheets if necessary):*

Date of Action:	Entity Taking Action:	Action Taken:
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

- 21. Actions 2.** Have you ever had any action taken by healthcare institutions, other practitioners, insurance companies, health maintenance organizations or professional organizations that resulted in a suspension or revocation of privileges or the termination of employment? *If yes, please complete the sections below (attach additional sheets if necessary):*

Yes: ☐ No: ☐

Date of Action:	Entity Taking Action:	Action Taken:
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

- 22. Paid Claims.** You are required to provide a complete listing of all paid claims for the last ten years. This should include paid claims not only in Virginia, but in other states and countries as well. Print the city, use the two-letter state abbreviation, and print the country if non-US. For each paid claim, you may submit a brief description of the case for consumers to review. Please keep the text of each descriptions to 300 characters. Please provide this text on an additional sheet of paper.

Payment Year:	<u>Total US Dollar Amount</u>	City/State and/or Country	<u>Settlement / Judgment</u>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

Attestation:

I certify that the information provided in this questionnaire is true, complete, and accurate to the best of my ability. I further understand that providing incomplete or false information may constitute unprofessional conduct and may subject me to disciplinary action by the Virginia Board of Dentistry.

Signature

Date

Thank you for completing your questionnaire. Please keep a copy of your questionnaire for future reference. You do not need to return the Code Lists. By regulation, your information must be received by the Board within 60 days of the initial request.

Board of Dentistry
6603 West Broad Street
5th Floor
Richmond Virginia 23230-1712

If you have questions, please call - (804) 662-9906

QUESTIONNAIRE REFERENCE

Active License: Licensee may practice in Virginia.

Address of Record: The one address that the licensee provides the Board to receive official communication including renewal of license, licenses, notices, or other essential written communication.

Board Certified: Licensee has met the requirements for certification as defined by the American Dental Association's Council on Dental Education and Licensure www.ada.org

Board Eligible: Licensee is not "Board Certified" but is recognized by the American Dental Association's Council on Dental Education and Licensure www.ada.org

Continuing Education: The additional training the licensee pursues.

Cosmetic Procedures: Aesthetic or cosmetic procedures as identified in 18 VAC 60-20-290 that involve area above the clavicle or within the head and neck region of the body.

Email us at: www.denltc@dhp.virginia.gov

Fax us at: 804-662-7246

Hospital Affiliations: Any type of relationship a licensee has with a hospital either as an employee (W2form), independent contractor (1099 form), or via type of privilege, not limited to but including Courtesy, Locum tenens, Admitting, Emeritus, Honorary, Temporary, etc. The definition of the various categories of privilege varies from hospital to hospital.

Legal Documentation: A name change requires a copy of the court order indicating the name change, marriage certificate, divorce decree, a letter from your lawyer, or a letter from the Social Security office.

Mail: Board of Dentistry's mailing address:

Virginia Board of Dentistry
6603 West Broad Street, 5th Floor
Richmond, VA 23230

Medicare participating Provider: A licensee who contractually accepts the participating provider fee schedule.

Optional Data Elements: These elements are not required by law or regulations but may enhance your profile. These elements include:

- Continuing Education
- Days of Week at Practice Locations
- E-mail Address
- Foreign languages spoken at secondary practice locations
- Honors and Awards
- Maiden name
- Medicare participation
- Telephone Number at Practice Locations
- Translation services at secondary practice locations
- Website Address

Paid Claim: In the context of malpractice, a paid claim is a payment made to a person in response to a claim. It may be in the form of a “judgment” or “settlement.”

Peer-Reviewed Literature: A journal or publication whose articles are reviewed and selected by an editorial board comprised of individuals having attained similar certification, education, training, and experience.

Practice Address: A location where the licensee engages in practice of dentistry regardless if patients are seen. Practitioners may designate a primary practice address and additional practice addresses.

Self-reported: The licensee has reported this information and assumes responsibility for its accuracy and completeness. It has not been verified or confirmed by the Board of Dentistry, however, the Board reserves the right to audit or investigate.

Settlement: In the context of a paid malpractice claim, a settlement is an agreement between the parties in which payment is made to the plaintiff to resolve the claim without proceeding to court. A court may approve the settlement, but it is not an award of the court. A settlement does not necessarily mean that the practitioner admits liability for damages sustained by the plaintiff.

Total US Dollar Amount: The value of the total amount of the paid claim in United States funds.